



Langley Research Center Safety Alert

Date: July 17, 2003

TO:

All Facility Safety Heads and Facility Coordinators

FROM:

SA-06-03

429/Head, Safety and Facility Assurance Office, OSMA

SUBJECT:

Close Call Resulting From Unintentional Operation of

Fiber Optic Cable Cutter

On May 30, 2003, an electrically-initiated fiber optic cable cutter in the lower pod of an aircraft unintentionally functioned during a 60-day armament functional check. Fortunately, this event caused no personnel injuries or equipment damage. What we learn from a close call like this can prevent a serious accident in the future.

It was concluded that this close call occurred because of a failure to update the maintenance checklist and train personnel after making a system modification. In this incident, the lower aircraft pod had been modified to accept the fiber optic cable cutter, but the checklist had not been revised to reflect procedures for disconnecting the fiber optic cable cutter. The employee performing the functional check loosened, but did not completely separate the cannon plug, which allowed the firing circuit to be completed during the functional test. To prevent the occurrence of this incident in the future, a new checklist has been developed and all maintenance personnel have been trained to use the new checklist.

This close call emphasizes the importance of updating Standard Operating Procedures (SOPs) and checklists, along with retraining personnel on the SOP changes, whenever changes are made to a system. Safe operations require: (1) a thorough understanding of the operational hazards, (2) development of written procedures/checklists, and (3) training and adherence to the procedures/checklists.

Take a moment now to examine procedures you follow at your facility. Are the published revisions current? Are revisions explained to operators such that they understand the associated hazards? Are the procedures being followed?

If you have any questions, please contact the undersigned at 43069.

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421/AHP